



Department of Veterans Affairs

**REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL  
RECORDS PROTECTED BY 38 U.S.C. 7332**

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**➡** The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

**ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.**

**TO: DEPARTMENT OF VETERANS AFFAIRS** (Print or type name  
and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE      ☐ ALCOHOLISM OR ALCOHOL ABUSE      ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)      ☐ SICKLE CELL ANEMIA

**INFORMATION REQUESTED** (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY      ☐ COPY OF OUTPATIENT TREATMENT NOTE(S)      ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on \_\_\_\_\_ (date supplied by patient); or (3) under the following conditions(s):

**I understand that my VA doctor's opinions are not "official" VA decisions regarding whether or not I will get other VA benefits. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.**

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

**FOR VA USE ONLY**

IMPRINT PATIENT DATA CARD (Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY